VISUAL DISTURBANCES DUE TO MALARIA.

SULZER (*Klin. Monatsbl. f. Augen.*, July, 1890) has made an exhaustive study of the affections causing disturbances of vision which are more or less directly referable to malarial poisoning. He divides them into two categories. The first includes the cases connected with a malarial cachexy. The second embraces those characteristic of the acute febrile attacks. In the first are: Chronic optic neuritis, leading, the bad cases, to melanosis of the papilla; diffuse infiltration of the vitreous; hæmorrhagic extravasation in the peripheral portions of the retina (these, according to Poncet, are always met with in individuals dying from malarial cachexy); sudden and incurable blindness, due, probably, to cortical hæmorrhages or embolisms. In the second category are: 1. Periodic amblyopia without any ophthalmoscopic changes. The degree of the amblyopia is variable, but in some cases may amount to complete amaurosis lasting for several days, and yet followed by complete recovery on using quinine. 2. Venous hyperæmia of the papilla and retina. 3. Large hæmorrhages in the neighborhood of the papilla and macula.

TENONITIS FOLLOWING INFLUENZA.

FUCHS (*Wien. klin. Wochenschrift*, 1890, 11) observed four cases of idiopathic tenonitis during the influenza epidemic. One reason for believing in the influenza as the direct cause of the inflammation was that three of the cases were met with within a fortnight, whilst Fuchs had only once previously come across a similar case. In two of the cases a more definite confirmation of the diagnosis was afforded by the discovery of pneumococci (Fränkel-Weichselbaum) in cultivations made from the secretion. One case went on to suppuration.

DISEASES OF THE LARYNX AND CONTIGUOUS STRUCTURES.

UNDER THE CHARGE OF

J. SOLIS-COHEN, M.D.,

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EPITHELIAL SARCOMA OF THE NASAL PASSAGES INVADING THE FRONTAL LOBES OF THE BRAIN.

M. G. DURANTE reports (*Arch. de Lar. de Rhin.*, etc., June, 1890) an instructive case which exemplifies the necessity of caution and of precaution in attacking suspicious intra-nasal morbid growths.

A man, sixty years of age, came to Dr. Luc's clinic for what he supposed was a simple nasal polyp. The right passage was seen to be occluded by an immobile, fungous grayish mass, which bled readily. Apart from the interference with respiration, and slight debility in consequence of recurrent epistaxes, a tendency to cephalalgia and some tendency to being dazzled, the patient had appeared perfectly well, expressed himself freely, and presented no indication of intellectual trouble.

Recognizing a malignant tumor inoperable without external access, Dr. Luc sent the patient to the *Hôpital Laënnec,* where, in the view of the absence of cerebral symptoms, it was proposed to operate the next day. As the patient arose in the morning, he tottered over and fell dead. The autopsy, twenty-fours hours later, revealed at the base of the cranium a grayish, puriform, and malodorous grumous mass covering the entire space comprised between the anterior portion of the cribriform plate of the ethmoid bone and the wings of the sphenoid. The cribriform plate was perforated and destroyed on both sides; and so was the body of the sphenoid, the destruction being more complete on the right side than on the left. The bones were represented by a semi-liquid puriform clot, through which the canulated sound penetrated into a vast anfractuous cavity formed of the nasal fossæ and the ethmoidal, sphenoidal, and maxillary sinuses largely opened by destruction of their walls. From this orifice a portion of the tumor was removed as an irregularly-lobulated grayish neoplasm, almost completely softened and diffluent in some places, and of fleshy consistence in others, but readily reduced to grumous masses by digital pressure. The dura mater and pia mater of the anterior region of the base of the brain were destroyed. All that portion of the base of the brain comprising the inferior face of the two frontal lobes, the anterior perforated spaces, and the chiasm of the optic nerves, was bathed in this same puriform matter, and showed, after being washed with a jet of water, that it was invaded by the neoplasm. The right olfactory nerve was completely destroyed, and but a number of shreds of the left remained, imbedded in pus and false membranes. The chiasm also was covered and invaded by the false membranes, and softened to such an extent as to make it difficult to understand how sight had been preserved. The inferior portion of the first frontal convolution, the beak of the corpus callosum, and the gray layer of the optic nerves had disappeared; and in their stead was a cavity, the dimensions of a small egg, occupying the two frontal lobes. This cavity was filled with a gray-brownish, grumous, purulent liquid, of an infectious odor. The walls were covered with a corrugated grayish membrane with fine green punctations. The cavity was entirely within the frontal lobes, and was separated from the convexity by a thickness of cortical substance, varying from one centimetre to one centimetre and a half. Behind and below it was separated from the lateral ventricles by a very thin layer of nerve substance which broke through on opening the brain. The ventricles contained but a few drops of liquid, and their walls absolutely healthy, were not even injected. The optic layer and the striated bodies were healthy, and in fact there were no other morbid conditions in the brain.

The tumor, on microscopic examination a sarco-epithelioma, had destroyed the superior walls of the nasal cavities, and had progressively invaded the frontal lobes, where it had produced an abscess, possibly in consequence of the secondary penetration of septic elements, but more probably in consequence of softening and disintegration of its central portions.

Clinically, the observation is curious in view of the latence of cerebral symptoms, which were not suggestive of any invasion of the encephalon. It shows, too, once more, the prudence requisite in undertaking extirpation of nasal growths, for there was no serious contra-indication in this instance, and yet, in all probability, sudden death would have ensued during an operation.

It is interesting, too, as a fresh example of the tolerance of the brain, and particularly of the frontal lobes, to lesions which should apparently have determined death, or at least grave nervous symptoms long before they had reached the extent they had undergone.

In concluding, the remark is made that, as both frontal lobes were equally affected, there could be no assumption that the unknown functions of one side had been here supplemented by an intact homologous region of the other side.

A New Method of Nasal Irrigation.

Pins, of Vienna (*Mercredi Médical*, April 20, 1890; *Rev. de Lar.*, etc., August 15, 1890) uses a small Wolfe bottle, to the longer tube of which a mouthpiece is attached by rubber tubing, while a nozzle is similarly attached to the short tube. The patient blows the liquid into one of his nasal passages, and, as the forced expiration occludes the rhinopharynx, the liquid escapes by the other nostril.

Posterior Hypertrophies of the Turbinates.

Dr. Harrison Allen, of Philadelphia, in an excellent clinical article (*University Med. Mag.*, August, 1890), enforced by a number of briefly narrated cases in illustration, shows that direct surgical interference is by no means always necessary. When the anterior end of an inferior turbinate body is small and well located above the floor of the passage, he finds it much better to apply astringents or caustics to the free inferior border, which is apt to impinge upon the floor of the passage, or to operate with the view of increasing the diameters of the nasal passages by resecting the triangular cartilage and drilling away superfluous projections from the septum; plans which in his hands have been quite successful in reducing the bulk of the posterior masses.

He urges care to avoid mistaking for posterior hypertrophies a normal condition due to a congenital defect of the vomer, which he has termed *recedent.* Thus, when the vomer unites with the floor of the nose at the region of the maxillo-palatine suture, the posterior ends of the turbinals will approach each other, and even come into contact from absence of the septum which would have kept them apart, so that they appear to be protruding into the free space of the rhinopharynx.

Several instances are narrated in which treatment of concomitant pathological conditions succeeded in curing, or greatly relieving, catarrh and asthma without any topical treatment of the posterior hypertrophies; complete relief ensuing in some of the cases even without any diminution of bulk in the posterior hypertrophies. In other cases the posterior swellings diminished or disappeared.

Dr. Allen concludes that it is a good rule to suspend treatment of posterior hypertrophies until all other morbid conditions have been carefully corrected, when, indeed, it may be found, as in three of the instances cited, that they will not require treatment at all.